



Psychometric properties of a short form of the Affective Lability Scale (ALS-18)

Amy E. Look^a, Janine D. Flory^{b,c,*}, Philip D. Harvey^d, Larry J. Siever^{a,c,e}

^a Mental Illness Research, Education and Clinical Center (MIRECC), James J. Peters VA Medical Center, Bronx, NY, USA

^b Department of Psychology, Queens College, CUNY, Flushing, NY, USA

^c Psychiatry Service, James J. Peters VA Medical Center, Bronx, NY, USA

^d Department of Psychiatry and Behavioral Sciences, Emory University School of Medicine, Atlanta, Georgia

^e Department of Psychiatry, Mount Sinai School of Medicine, New York, NY, USA

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ABSTRACT

Psychometric properties of a short form of the Affective Lability Scale (ALS) that was developed in a non-clinical sample (i.e., undergraduate students) were examined in a sample of people diagnosed with Cluster B DSM-IV Axis II personality disorders ($n = 236$), other personality disorders ($n = 180$), and healthy comparison participants ($n = 164$). The total score of the ALS-18 score correlated strongly with the original 54-item scale ($r = .97$) and aspects of convergent and discriminant validity of the ALS-18 subscales (Anxiety/Depression, Depression/Elation, and Anger) were evaluated using self-report measures of affective and psychosocial functioning in the domains of affect intensity, anxiety, anger, and minimization/denial. Clinical utility of the scale was also demonstrated; participants diagnosed with Cluster B personality disorders reported higher affective lability scores, and healthy control participants reported lower scores, relative to individuals with Cluster A or Cluster C personality disorders ($p < .001$). Confirmatory factor analyses were conducted and demonstrated reasonably good fit to the data but future research is needed to test the three factor substructure of the ALS-18 against alternative factor models in samples that include clinical and non-clinical participants.

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1. Introduction

Dysregulated affect is a primary feature of several types of psychopathology, including depression, bipolar disorder, borderline personality disorder (BPD), and intermittent explosive disorder (Benazzi & Akiskal, 2005; Bunce & Coccaro, 1999). One aspect of affect dysregulation is affective lability, which refers to rapid shifts in outward emotional expressions. Affective lability is particularly relevant to BPD and bipolar spectrum disorders, although the disorders appear to differ in lability between affective states (Henry et al., 2001; Koenigsberg et al., 2002). Mood disorders, including bipolar spectrum and depressive disorders, are associated with greater lability in terms of depression, elation, and Depression/Elation oscillation relative to BPD, which is associated with greater lability in terms of anger, hostility, anxiety, and oscillation between depression and anxiety (Koenigsberg et al., 2002; Trull et al., 2008).

The Affective Lability Scale (ALS; Harvey, Greenberg, & Serper, 1989) was created to measure this construct and is a 54-item scale in which people rate their agreement with statements regarding

the tendency of their mood to shift between what they consider normal mood to the affective domains of anger, depression, elation, and anxiety as well as their tendency to oscillate between depression and elation and between depression and anxiety. Items were created to tap into subjective experiences, physiological perceptions, and behaviors using six subscales (Harvey et al., 1989). Recognizing that this self-report measure is lengthy, Oliver and Simons (2004) created an 18-item short form (ALS-18) of the 54 item ALS. The ALS-18 comprises a three factor model of affective lability, with each factor retaining at least two items from each of the original six scales of the ALS, and was found to correlate highly with the original ALS total score ($r = .94$). In addition, in this non-clinical sample, the ALS-18 Anxiety/Depression scale was strongly associated with depressive symptoms ($r = -.47$), but less strongly with affective intensity ($r = -.24$) and emotional control of aggressive impulses ($r = -.19$). In contrast, the ALS-18 anger scale was associated with emotional control ($r = -.47$).

Given that the ALS-18 was created using responses from a non-clinical sample of undergraduate students, the current analyses aimed to evaluate the structure and construct validity of the ALS-18 in a sample that included people with DSM-IV Axis II personality disorders and healthy comparison participants. Analyses included group comparisons across diagnostic groups that would be expected to vary in levels of affective instability (e.g., people with a Cluster B personality disorder (PD) diagnosis versus people

* Corresponding author at: Department of Psychology, Queens College, 65-30 Kissena Blvd., Flushing, NY 11367, USA. Tel.: +1 718 997 3465; fax: +1 718 997 3232.

E-mail address: janine.flory@qc.cuny.edu (J.D. Flory).

with Cluster A or Cluster C personality disorders and healthy control participants). Additionally, a confirmatory factor analysis was conducted on the three factor model in the total sample to evaluate model fit.

2. Method

2.1. Participants

Participants were 580 adults recruited for participation in the Mood and Personality Disorders Research Program through advertisements and clinical referrals. The longstanding aims of this research program are to evaluate the neurobiological and genetic correlates of DSM-IV Axis II personality disorders, with an emphasis on BPD and schizotypal personality disorder. Data for the current analyses were collected from January 1999 to February 2008, during which time the recruitment strategies and study exclusion and inclusion criteria for the research program did not change appreciably. Individuals with a lifetime history of schizophrenia or bipolar disorder, significant medical illness, or current substance abuse or dependence were not eligible for participation in the research program.

Participants in the current analyses included 236 people who met criteria for one or more DSM-IV Axis II Cluster B diagnosis, 180 people who met DSM-IV Axis II criteria for at least one other PD (OPD), but did not meet criteria for a Cluster B disorder, and 164 healthy controls (HC) who did not meet criteria for any DSM-IV Axis II disorders, and also did not meet criteria for a major DSM-IV Axis I disorder. The distribution of rater assigned diagnoses (Cluster B, OPD, HC) across two 4.5 years epochs, January 1999 to July 2003 ($n = 195$) and August 2003 to February 2008 ($n = 385$), was comparable. During each epoch, 40–41% of the sample was assigned a Cluster B diagnosis relative to 30–33% OPD and 26–29% HC. Although more participants were enrolled into the research program in later years, the distribution of diagnoses was similar ($\chi^2(2, n = 580) = .78, p = .68$).

Note that people in the Cluster B group included: borderline personality disorder = 199 (84%), antisocial personality disorder = 37 (16%), narcissistic personality disorder = 68 (29%), histrionic personality disorder = 19 (8%), paranoid personality disorder (PPD) = 89 (38%), schizotypal personality disorder (SPD) = 55 (23%), obsessive compulsive personality disorder (OCPD) = 58 (25%), dependent personality disorder (DPD) = 17 (7%), and avoidant PD (AvPD) = 61 (26%). The OPD group included: PPD = 37 (21%), schizoid personality disorder = 11 (6%), SPD = 75 (42%), OCPD = 67 (37%), DPD = 8 (4%), AvPD = 61 (34%), and personality disorder not otherwise specified = 9 (5%). These percentages sum to more than 100 because of multiple overlapping diagnoses. Demographic characteristics of the three groups are presented in Table 1.

Table 1
Demographic characteristics by group ($n = 580$).

	Cluster B ($n = 236$)	OPD ($n = 180$)	HC ($n = 164$)
Mean age (SD)	35.08 (10.4)	36.24 (12.1)	30.04 (9.2)
Male (% of sample)	108 (45.8%)	105 (58.3%)	72 (43.9%)
<i>Ethnicity/racial distribution: n (% of sample)</i>			
African/American	57 (24.2%)	51 (28.3%)	23 (14.0%)
Asian	14 (5.9%)	14 (7.8%)	27 (16.5%)
Caucasian	102 (43.2%)	75 (41.7%)	90 (54.9%)
Hispanic	53 (22.5%)	32 (17.8%)	22 (13.4%)
Unknown/other	10 (4.2%)	8 (4.4%)	2 (1.2%)

Note: Cluster B = borderline personality disorder, narcissistic personality disorder, antisocial personality disorder, histrionic personality disorder; OPD = other personality disorders (Clusters A and C personality disorders); HC = healthy control participants.

2.2. Measures

Affective lability was measured with the Affective Lability Scale (ALS; Harvey et al., 1989). Each item is rated along a 4-point (0–3) scale, ranging from “Very uncharacteristic of me” to “Very characteristic of me”. The six subscales assess shifts between euthymia and: (1) depression, (2) anger, (3) anxiety, (4) hypomania, as well as (5) biphasic shifts between hypomania and depression, and (6) shifts between anxiety and depression. The ALS-18 developed by Oliver and Simons (2004) is a selection of 18 items from the ALS that were selected based on an exploratory factor analysis and retained on the basis of the eigenvalue greater-than-one guideline and the scree test. The authors also excluded items based on low item-total correlations. Participant answers to the resulting short form are rated on the same 4-point scale as the original ALS and include a total score as well as three subscales: Anxiety/Depression, Depression/Elation, and Anger.

Affect intensity was measured by the Affect Intensity Measure (AIM; Larsen, Diener, & Emmons, 1986), a 40-item, self-report measure in which subjects rate the degree to which they characteristically experience their moods on a 6-point (1–6) scale with anchors ranging from “Never” to “Always”. Trait anxiety was measured by the State-Trait Anxiety Inventory (STAI; Spielberger, Gorsuch, Lushene, Vagg, & Jacobs, 1983), a 40-item, self-report measure in which subjects rate the degree to which they feel anxious on a 4-point (1–4) scale ranging from “Not at all” to “Very much so”.

Anger was assessed using the State-Trait Anger Expression Inventory (STAXI; Spielberger, 1991), a 44-item self-report measure in which subjects rate the degree to which they feel angry on a 4-point (1–4) scale ranging from “Not at all” to “Very much so”. Subscales examined here include Trait Anger, Anger-In, and Anger-Out. The minimization/denial scale from the Childhood Trauma Questionnaire (CTQ; Bernstein & Fink, 1998), which taps a socially desirable responding style was also included.

2.3. Procedure

Participants were interviewed for the presence of DSM-IV Axis I disorders using a semi-structured interview based on the Structured Clinical Interview for DSM-IV (SCID-I; First, Spitzer, Gibbon, & Williams, 1997). The presence of DSM Axis II disorders was assessed using the Structured Interview for DSM-IV Personality Disorder (SIDP-IV, Pfohl, Blum, & Zimmerman, 1996), although HC participants were not administered the full SIDP interview. The majority of the diagnostic interviews (approximately 75%) were conducted by two doctoral level clinical psychologists, who were assisted at times by other doctoral level psychologists, masters level psychologists and one clinical social worker. All diagnoses were assigned after consensus with a licensed clinical psychologist. The analyses conducted to evaluate convergent and divergent validity are based on a battery of self-report measures administered shortly after acceptance into the research program. Written, informed consent was obtained and the protocol was approved by the IRB committees at the James J. Peters VA Medical Center and Mount Sinai School of Medicine.

3. Results

Responses to all 54 scale items of the ALS comprised a normal distribution across the full sample. Prior to analysis, the data were inspected for missing responses and one person's data were removed from the first sample because he/she did not complete seven items. Correlational analyses examining convergent and discriminant validity of the scale were conducted and clinical utility

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